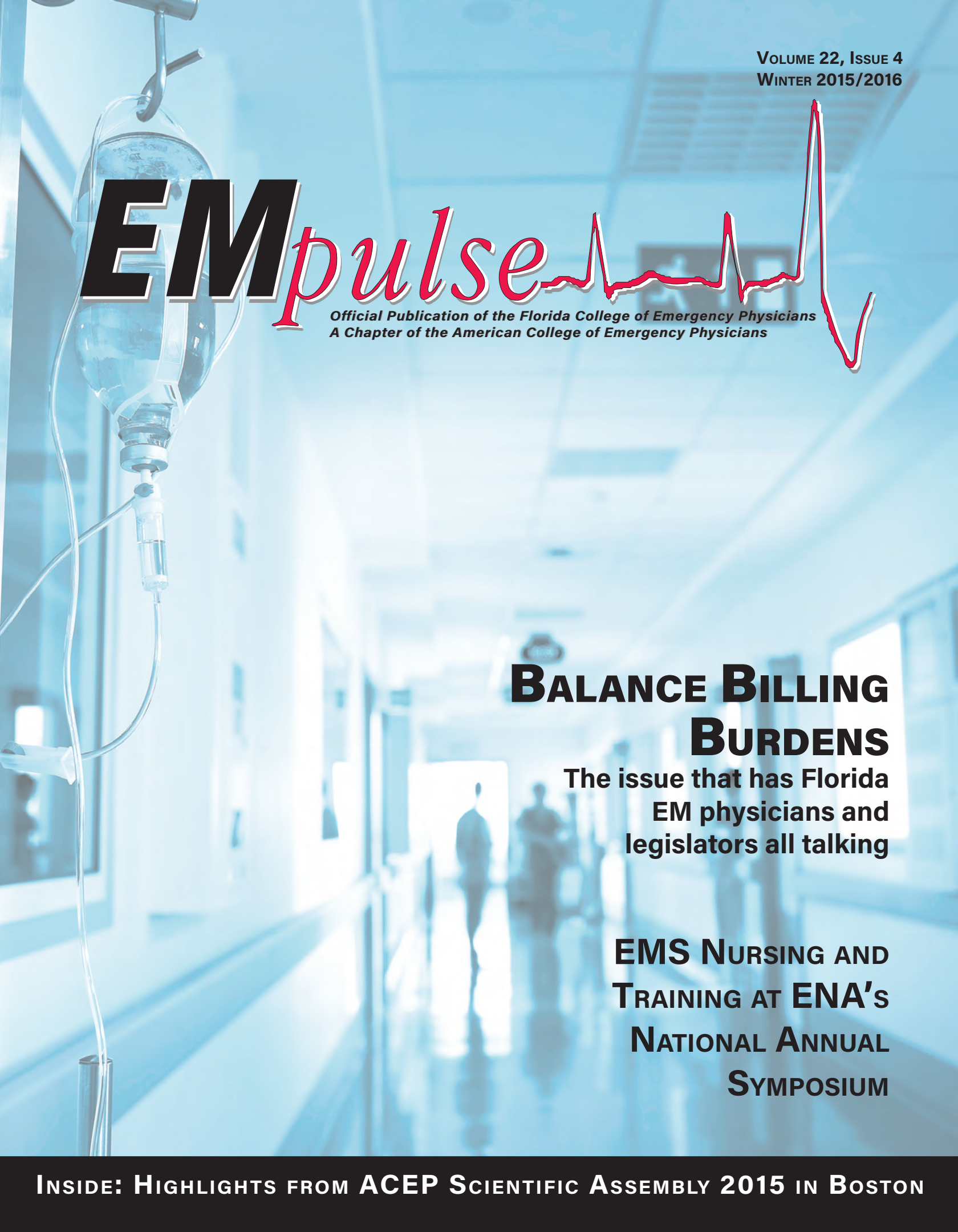
Volume 22, Issue 4
Winter 2015/2016

EMpulse

Official Publication of the Florida College of Emergency Physicians
A Chapter of the American College of Emergency Physicians



Balance Billing Burdens

The issue that has Florida EM physicians and legislators all talking

EMS Nursing and Training at ENA's National Annual Symposium

Inside: Highlights from ACEP Scientific Assembly 2015 in Boston

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TAMPA BAY, FL
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TAMPA BAY, FL
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TAMPA BAY, FL
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Published by:
Liberty Creative Group
800 Waterway Place
Longwood, Florida 32750
Phone: 407-960-4270
Fax: 407-260-8614
www.liberty-creative.com

Chapter Updates

Features

President's Message

There is much to do in this coming year. Highest on our agenda is addressing a reimbursement issue that will have a huge impact on all of us. Insured patients are often unaware of or unprepared for their financial obligations when they seek medical care. Narrow insurance networks and a shift to high deductible plans with increased co-pays are the new reality. Patients may receive "surprise bills" and insurers paint this picture as physicians taking advantage of patients. The reality is the patients are "surprised" to discover their insurance policy doesn't actually cover the costs of their needed care.

Steven Kailes, MD, FACEP
FCEP President

Florida legislators will likely change the law on this issue by making it illegal to bill patients the balance due for services rendered, regardless of the insurance plan type (already the case for HMOs). For emergency medicine, this balance-billing ban will drastically reduce our total revenues for all of the patients we see, since we effectively lose money on the 70% of patients we see who are not covered by commercial insurance plans. Emergency medicine is uniquely affected by this problem due to our EMTALA mandates, where we provide care first and deal with reimbursement later. Drastic cuts in revenue may lead to ED workforce changes, negatively affecting patient care and our state's health care safety net (which is the care we provide in the ED every day).

I have a "silver-level" PPO plan and pay over $14,500 per year for "coverage" for my family of four. I'm still obligated for up to $7,200 for our "deductibles." How can the typical person afford this? They can't. The insurer, with premiums in hand, shifts costs to patients and physicians. Patients are stuck with medical debt and emergency physicians usually cannot collect their fees. Insured patients effectively become "self-pay" because of their high deductibles. We typically collect four cents on the dollar for self-paying patients.

Charges vary for Florida's emergency physicians but can average around $679. Most physician groups contract with most insurers, eliminating this billing issue for those patients. However, insurers pay an average of only $307 for an EM patient. Emergency physicians typically collect less than 15% of the remaining balance due.

Some insurance plans pay an arbitrarily determined amount based on a per-centage of Medicare "allowable." Medicare is a flawed standard for payment. Medicare was intended to be a payment system based on provider's costs but it has become a political poker chip with the federal government's budget and increasing deficit. Medicare payments are no longer based on provider costs and Medicare reimbursement is decreased in order to offset other expenses in the federal budget. Medicare payments have been declining relative to other economic indices for over a decade. Tying provider payments to any percentage of Medicare is virtually guaranteed to be a declining physician reimbursement model.

We face an uphill struggle due to our limited resources. However, our team is constantly working on this issue, meeting with key individuals and groups by offering solutions to help the patient and yet keep our fragile safety network intact. Please contact me if you are willing to join us in this effort.

FCEP is busy with many other issues. We are in the midst of developing a new strategic plan for the College. We are also working to provide greater educational offerings, additional advocacy regarding regulatory and legislative issues, as well as personal and professional development tools and resources to improve what you get in return for your membership. We are now offering a written EM board review course in the late summer and I expect next year's course will be even better than our course this past summer.

I hope you'll join us in Tallahassee for EM Days, January 18-20, where we'll advocate for your patients, for you, and the practice of emergency medicine. Lastly, please join us in Naples, FL, August 4-7, 2016 for our annual Symposium by the Sea, where we will regroup, recharge and reconnect.

Have a Happy New Year!

Medical Economics Committee

Health Care Industry under the spotlight: "Unconscionable pricing"

Governor Scott continues his targeting of the Healthcare industry with his Commission on Healthcare and Hospital Funding releasing proposed legislation to create transparency. Ironic that hospitals profits are an issue to the creator of a for profit hospital empire that figures prominently on the Washington Post's top 50 list of "price gouging hospitals." Never-the-less, the proposal's purported objectives – consumer protection, transparency, and value are all noble ideals that EM providers support. Indeed some of the elements within the proposed legislation may even make sense and further these ideals. But when inflammatory rhetoric such as "unconscionable pricing" is used - and further defines as prima facie evidence that a price is unconscionable if a retail price charged exceeds the average discounted price by more than 15% - one quickly sees this as a very anti-free market attempt at price fixing. What other industry has government outlawing discounts of >15% to their preferred customers? Or controlling the wholesale (contracted discounted rates to preferred customers) vs. retail (non-discounted) price?

Daniel Brennan, MD, FACEP
Medical Economics Committee Chair

The proposal also would create a new agency - the Florida Center for Health Information and Policy Analysis – a Comprehensive Health Information System charged with collecting data on quality measures and financial data. The quality and safety indicators suggested are already tracked by CMS and other national agencies, so it is hard to imagine funding devoted to a redundant service. The financial information to be captured includes charge data, which is already available publicly via FAIRHealthTM, a consumer friendly national database of charges. It would also capture payment information, and a broad range of health plan information such as plan costs (premiums, co-pay, deductibles, premium increases), coverage areas, credentials and numbers of providers, care quality, and member satisfaction. Much of this health plan information should be more clearly disclosed to consumers. As EM providers, transparency and disclosure should help the public understand the value of our services.

The "unconscionable" tone of this proposed legislation seems likely to generate strong opposition from the Florida Hospital Association and likely little enthusiasm for the specifics of this bill in our Republican legislature. But it does affect the conversation that will occur about health care pricing. Representative Trujillo (Miami) has re-filed legislation seeking to ban balance billing for Emergency services (HB 221). The filed version closely matches last year's HB 681 / SB 516. The bill protects patients from out-of-network balance billing but allows insurers to control payments. Limitation of payments (with a Medicare allowable option) will affect both out-of-network and contracted rates with devastating effects on EM revenue. Inevitably, adequacy of EM and subspecialty resources would be affected. FCEP has been very involved – meeting with the Office of Insurance Regulation, CFO Atwater's Insurance Consumer Advocate Forum and dozens of legislators - to present data and promote solutions. We worked in concert with the Florida Medical Association on draft language which would eliminate balance billing by expanding the existing HMO language (where OON balance billing is prohibited) to the PPO arena. We included clarification of the "usual and customary provider charges" language in the existing HMO statute which seems to be conveniently misinterpreted by many payors to mean their usual payment (allowable) rather than the plain language provider charges stated.

In the spirit of transparency and consumer protection the FMA-FCEP draft specified that the usual and customary charge would be defined by the FAIRHealth 80th percentile charge. This reference would also protect payors against unilateral egregious fees by individual providers. Reflecting the unique difficulty in EM to collect co-pays and deductibles from patients, the draft also removed the obligation from EPs to serve as collection agents by requiring insurers pay providers directly and have the insurer collect co-pays, co-insurance and deductibles from their subscribers according to their plan design. Our draft meets all of the consumer advocate's "checkboxes" that the legislators are being tasked to include– balance billing limitation, disclosure/transparency, dispute resolution process, fair and reasonable rates, and network adequacy. We will follow ongoing conversations – such as alternative approaches other states have taken, and continue to advocate for solutions that protect consumers while also protecting the EM safety net. It is also possible the narrow focus of the current bill will become much larger if out-of-network surprise bills and hospital costs are included. Currently (11/23/15) no Senate companion bill has been filed, nor has an expected amendment to Rep. Trujillo's filed bill surfaced. This issue has by far the largest potential impact on your career so your involvement directly, or via contributions to the FCEP PC would be wise. The Legislative session begins 1/12/16, just prior to FCEP's EM days January 18-20.

Government Affairs Committee

Joel Stern, MD, FACEP
Government Affairs Committee
Co-Chair

The GA committee met in Orlando on November 11, 2015. Once again, our number one topic was Balance Billing and Out of Network Payments. In a repeat of last session, Representative Trujillo has filed another bill which would eliminate Balance Billing for Out of Network PPO accounts for Emergency Services. This time it's HB 221.It was filed as a placeholder, with the intention of substituting with a strike all amendment. This essentially means that the Bill Language will be substantially changed. However the Bill's main intention, which is elimination of Balance Billing for Emergency Services, should remain. As of today, no Senate companion Bill has yet been filed. The House Bill has been referred to three committees, the first of which is Insurance and Banking. On November 18th, this committee met in Tallahassee. On the agenda was a presentation by the Florida Consumer Advocate, regarding this issue. Also attending was FCEP Board member Dr. Dan Brennan. Dan gave a really great presentation to the committee. He spoke about potential issues regarding allowing Insurance companies the ability to set reimbursement rates for out of network charges. He also discussed the reality of high deductibles and coinsurance impacting patients' ability to access health care. Many thanks to Dr. Brennan for his tireless work on this issue.

Some late breaking news: This Bill was originally scheduled to be heard in committee on December 2. This has now been rescheduled for January 2016, during the early weeks of the legislative session. We will continue to follow this Bill's progress and continue to offer information and testimony on behalf of the Emergency Physicians of Florida.

Speaking of political advocacy, EM Days is right around the corner! We are meeting in Tallahassee January 18-20, 2016. We will again provide a CME program, as well as a Board Meeting, many interesting speakers, and the chance to meet and speak with our state senators and representatives. This is the premier EM advocacy event in Florida, so don't miss out! Register online and book your hotel room today!

We also convened a PC Board meeting after the GA Committee. Dr. Steve Kailes, FCEP President, has chosen to step down from the PC Board. We thank Dr. Kailes for his many years of service to the FCEP PCs. The GA Committee voted unanimously to recommend Dr. Damian Caraballo as the newest PC Board Director. This motion was presented to the FCEP Board the following day, and was again approved unanimously. Damian joins Dr. Sanjay Pattani and Myself on the PC Board of Directors. Welcome to the Board, Damian!

We are currently seeking donations for both of our PCs. They are Physicians for Emergency Care (PEC), and Emergency Care for Florida (ECF). PEM is intended for donations from Physicians, and ECF is intended for donations from businesses and corporate entities. Donations can be made online, on our website, by clicking on the support tab. We have also begun listing a donor's honor roll in EmPulse. In addition we have approved donor levels as follows:

ECF & PFEC PC Contribution Levels:
Code Gold: $25,000+
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Code Yellow: $500-$999
Code Pink: $250-$499
Code Green: $100-$249

I am happy to announce 100% participation in our PC by our Executive Committee. I have also asked the GA Committee members, and the rest of the FCEP Board to commit to 100% participation for this year. I would also like to take this opportunity to ask all of our college members to contribute to our PC this year. We are counting on your support to allow us to continue our work in Tallahassee. We are representing your interests in the State of Florida, to allow you to continue the very best delivery of emergency care.

EMS and Trauma in the State of Florida

Dagan Dalton, MD, FACEP
EMS/Trauma Committee
Co-Chair

I would like to begin by thanking all of the EMS Medical Directors in our state, for all of the work that they do. Being an EMS Medical Director is not the most rewarding job that an Emergency Physician can choose. It is a lot of non-clinical and often unrewarding work, but it DOES make a positive difference in patient care and in the lives of the EMTs and Paramedics. Again, thank you to our EMS Medical Directors. And I encourage each and every one of you to get to know them, and thank them as well.

On the update side:
Dr. Charles Sand of St. Joseph's in Tampa presented at the last FAEMSMD (Florida Association of EMS Medical Directors) meeting a draft update of the state Stroke Alert worksheet. Florida was the 1st of the 50 states to enact a Stroke Act for EMS, but much has changed since then. Most notably, Comprehensive Stroke Centers (CSCs) have been proven to play a much larger role with positive outcomes in stroke patients. They have traditionally been our EMS destination for strokes outside of the 3 hour (and then maybe the 4 1/2 hr) window, and possibly suspected SAH. But more recently, the CSCs have been proven to be of significant benefit in patients identified with LVO (large vessel occlusion) ischemic strokes. And these (LVOs) have been proven to be identifiable in the field by EMS personnel. Several EMS Agencies in our state have already implemented worksheets and transport destinations to CSCs in their protocols, with again positive outcomes. Florida EMS Medical Directors are doing their final review before submitting final form of draft of EMS Stroke Worksheet to state, perhaps for possible EMS rule change. Thanks to Dr. Sand and others for their efforts in getting us to this point.

The state has concluded several Rule Development Workshops re: CDC Field Trauma Triage Guidelines versus current Florida DOH EMS Trauma Alert Criteria. Decisions have been made, so we have been told, and now we are waiting for the new Triage Criteria to be published in Florida Administrative Weekly, and update of the Florida Administrative Code, or Rules based on Florida Statutes. We are sure to have news soon, and it will be published next issue, but please contact your local EMS Medical Directors for more current information. And again, please get to know your local EMS Medical Directors. We are all in this together and we want the same thing - quality patient care, from 911 through to disposition. Contact me at email address listed if you do not know your local EMS Medical Director, and I will get the contact info for you.

The newest Provisional Trauma Centers in our state are now waiting for their final State review and site visits in the next several months, to determine if they are to be designated Trauma Centers, or not. This will directly affect EMS Trauma Transport Protocols, as well. In the meantime, the State is looking at reorganization of Trauma Service Areas and Advisory Groups. There will be more to report on these and other State EMS/Trauma issues soon.

Membership & Professional Development Committee

Rene Mack, MD
Chair of the Membship & Professional Development Comittee

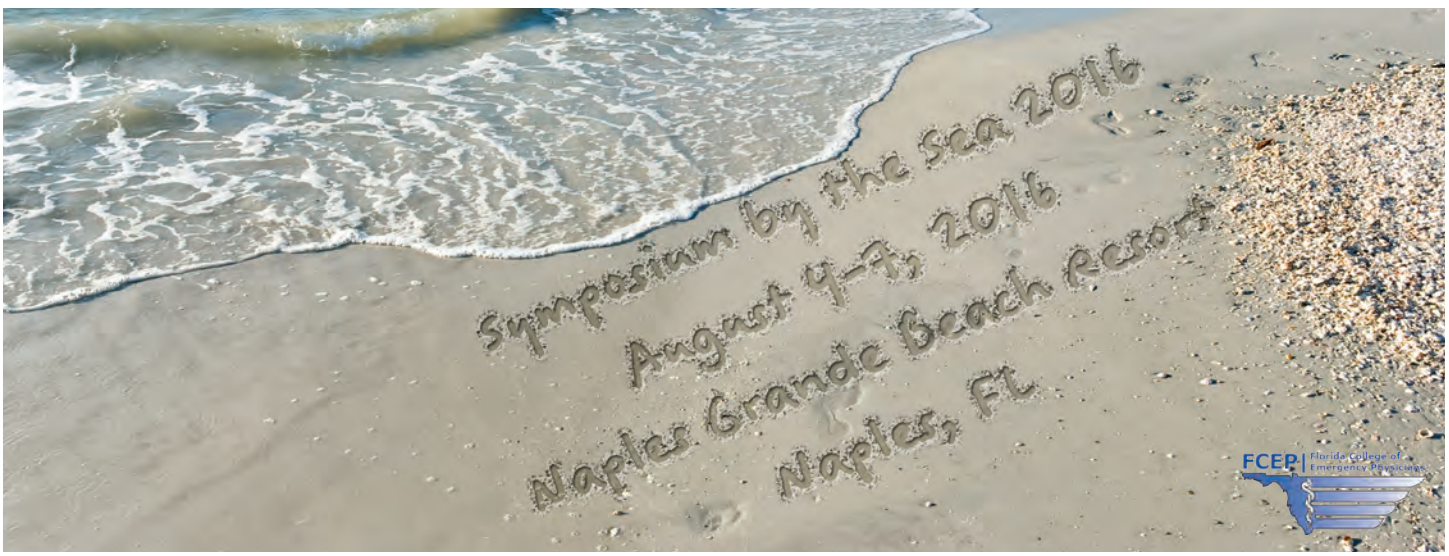
The Membership and Professional Development Committee has been hard at work for you over the past few months. The committees meetings that took place in November 2015 reveled some areas of success and some in need of further development. We continue to invest in outreach to our membership to ensure that all are aware of the many opportunities available through their ACEP/FCEP membership.

We have developed and are implementing a multi-pronged approach to recruitment and membership retention and they all involve you! If you are reading this article then you are likely an active member and understand the importance of remaining active in our organization. We look forward to welcoming the many physicians that relocate to Florida on an annual basis, maintaining relationships with the talented physicians produced at our residency programs and supporting the "seasoned" physicians already practicing in Florida.

In addition to the previously mentioned areas, we continue to expand our visibility and availability to the medical students in Florida who are seeking mentorship in cultivating a career in emergency medicine. FCEP has had the opportunity to provide and implement a Medical Student Mentorship Program. This program allows you to register to become a mentor as well as pairing medical students with an emergency medicine leader who is excited to help them to prepare for the next step(s) in their career. Are you interested in being a mentor or know of a student or group of students who would benefit from our program? Please visit the website at fcep.org and connect with the Medical Student Mentorship Program.

Our Leadership Academy participants, Drs. Staff, Carralero and Lai, continue to be active in their endeavors to deepen their knowledge and involvement in the many aspects of emergency medicine. They had the opportunity to experience the councillor meetings and function as ACEP Councillors/Alternate Councillors at ACEP15 in Boston. This allowed them in-depth interaction with the governing process of ACEP and lent significant appreciation of all that goes into making sure that we, the practicing emergency physicians, can continue with patient care with relative ease. They are currently working with the FCEP committees to help facilitate change and improvement within Florida and continue their journey toward more involvement within ACEP and FCEP. Are you interested in making you mark on emergency medicine or just unsure how to get started with becoming a more active member, join the next Leadership Academy class, you will definitely enjoy the experience!

As the year comes to a close, we take some time to reflect on the choices and impacts that we have made to help the membership grow as well as develop professionally. This committee has several purposes, with one of the main ones being to locate and remedy areas of need within our membership while ensuring that this organization remains available to all eligible practitioners. We strive to achieve our goals and while there is always more to be done we are on our way! Please continue to lend your support and we look forward to seeing you at EM Days in Tallahassee January 18-20, 2016!



"What Antidotes Should Be Stocked?"

By: Eileen Shomo, PharmD
Emergency *Medicine Pharmacy Resident (2nd year) -- UF Health Jacksonville*

Emergency medicine practitioners have become increasingly aware of the poisoned patient and corresponding treatment modalities. They know exactly which antidote is required to treat the child presenting with a swollen finger after a pigmy rattlesnake bite and the patient that ingested a bottle of acetaminophen. But, does your hospital have the life-saving antidote in stock? Is there adequate supply available treat your most critical patient? This is an important question for every emergency medicine practitioner to know the answer to, although getting to that answer can be tricky, as drug shortages and financial aspects of antidotes can have a pronounced impact on availability.

The World Health Organization supports the creation of a list of essential antidotes for institutions that accept emergency patients and in 2009, the American College of Emergency Physicians published guidance in the Annals of Emergency Medicine on this very matter in the form of an expert consensus.[1] The panel responsible for creating the document consisted of practitioners from a variety of practice settings including clinical toxicology, critical care, clinical pharmacy, and emergency medicine. Recommendations were accepted into the guidance based on a 75% group consensus in the absence of strong disagreement.

Overall, the panel recommended 24 antidotes that should be stocked at facilities that accept emergency patients. If more than one antidote was available for the same toxin, only the preferred agent was included in the recommendation. Out of the 24 antidotes, 12 antidotes were identified that should be available for immediate use in the emergency department. These antidotes are: atropine, calcium chloride, calcium gluconate, digoxin Immune Fab, flumazenil, glucagon, hydroxocobalamin, methylene blue, naloxone, physostigmine, pyridoxine and sodium bicarbonate. Nine antidotes were identified that should be available for use within 60 minutes: n-acetylcysteine, crotalidae snake antivenom, coral snake antivenin, deferoxamine, dimercaprol, fomepizole, octreotide, potassium iodide, and pralidoxime.

While it would be ideal for every institution to have each of these antidotes stocked in sufficient quantities, this is not the most feasible or financially viable charge. For example, coral snake antivenom is no longer manufactured and therefore cannot be easily obtained. The panel took this into consideration and recommended that a hazard vulnerability assessment (HVA) be performed to aid in the development of site specific antidote stocking recommendations. The HVA concept allows emergency centers to formally assess facility specific and patient population specific factors to help determine the need for an antidote and the amount required for the facility. Examples of factors assessed include patient referral patterns, antidote usage in normal practice as therapeutic agents, and the anticipated volume of use for each antidote being considered.

Last, the article provided guidance on the quantity of each antidote recommended to be stocked to treat a single 100 kg patient for 24 hours. Unfortunately, the authors did not detail how the recommended quantity was calculated, and some of the recommendations can surely be challenged. Additionally, the article was published over 5 years ago, and antidotes such as Intralipid® and insulin/dextrose were not included in the article. Despite these shortcomings, the article provides a solid platform for organizations to derive their antidote list, and many hospitals around the country have modified the panel's recommendations to fit the needs of the patients they care for. In conjunction with your local poison center (1-800-222-1222), this article can help practitioners answer the question, "What antidotes should be stocked?"

References:

1. World Health Organization: Guidelines for poison control. http://www.who.int/ipcs/ publications/training_poisons/guidelines_poison_control/en/index7.html

Florida International Trauma Life Support Update

As a nonprofit 501(c)(3) team of Emergency Medical Service professionals, Nature Coast EMS is an essential member of the health care community dedicated to improving the health and safety of our community through the provision of quality, innovative, timely and efficient clinical treatments. Nature Coast EMS also offers community classes from CPR and first aid to Matter of Balance classes for fall prevention.

Nature Coast EMS believes in giving back to the community by providing medical coverage for nonprofit organizations as well as volunteering time for various community projects. When new team members begin working at Nature Coast EMS they go through extensive weeks reviewing policies and procedures, medical protocols and other required training. The on-boarding process at Nature Coast EMS is called MOE (Miles of Excellence). New team members gain knowledge of Nature Coast EMS, protocols, ethics, standards, the community and more.

Some of their time is also dedicated to volunteer hours.

Many of these hours have been spent with The Key Training Center. The Key Training Center is a private nonprofit Florida 501(c) (3) organization dedicated to serving adults with developmental disabilities. The Key provides many programs and services to meet the social, vocational, residential/housing and advocacy needs of Citrus County and West Central Florida and has served more than 2,500 developmentally disabled citizens since opening its doors in 1966.

Nature Coast EMS team members volunteered their time washing vans, digging ditches, landscaping, cleaning windows and even deep cleaning an old kitchen located in the building that now is the adult day care on the Lecanto campus. These projects otherwise would have been delayed due to lack of man power and/or not having the funds to proceed.

The Key Training Center recently presented Nature Coast EMS with the “Organization of the Year” award at the annual Run For The Money Auction in July. Nature Coast EMS is honored to have been bestowed this award and hopes that other businesses and organizations follow suit in volunteering for The Key. Pictured is Katie Lucas who accepted the award on behalf of Nature Coast EMS.

Article submitted by Katie Lucas on behalf of Nature Coast EMS

Thank You for Your Continued Support!

Emergency Care for Florida Contributors through November 2015

- Emergency Physicians of Central Florida,LLP
- Emergency Resource Group

Physicians for Emergency Care Contributors through November 2015

- Aaron Wohl
- Ademola Adewale
- Alexander Gonzalez
- Alfredo Tirado-Gonzalez
- Alkesh Brahmbhatt
- Amabel Cabatu
- Ashley Norse
- Bradford Bowls
- Daniel Brennan
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- William Poole

Residency Matters

As the year comes to an end, lets catch up with our emergency medicine residency programs and see what they've been up to.

Florida Hospital
Jessica Aun, DO
PGY II Florida Hospital Emergency Medicine

Happy Holidays from Florida Hospital East! It's hard to believe that another residency year is halfway over. As always, we've been having a great time here in Orlando! Improvements are constantly happening throughout our program. Our new Pediatric Emergency Department recently opened at the East Campus and is pulling in tons of great pediatric cases for the residents. We recently had one of our famous wellness days where our attendees, residents, and medical students put their mad athletic skills to the test with a field day full of sack racing, capture the flag, water balloon and bean bag tossing. In the meantime, we're already in the thick of the new interview season with great interview dinners where we are meeting awesome prospective new residents. We love the process of finding our new crew! We all wish you and your families a fabulous holiday season and Happy New Year!!

Another academic year has been underway and "the season" seems to be starting early, as our ED has been bustling busier than usual for this time of year. That is quite alright though, as we have a stellar group which includes a solid group of interns. Over the past few months we have continued to take part in various state & national conferences doing SimWars, CPC competitions, and more. I'm proud to also say when not with nose in the books or running around the ED, I worked with some stellar students from two of the local south Florida Medical schools for the first large collective Wilderness Emergency Medicine Workshop that had representation from all four south Florida medical schools (FAU, FIU, UM, NSU) and also Ross University.

Where are our seniors going to next year? Most of our seniors are busy interviewing at various places around Florida for jobs, however I am proud to say that I will be staying in Florida as one of UF Gainesvilles EMS Fellows! (Go Gators!)

Mount Sinai
Benjamin Abo, DO EMT-P

Orlando Health
Tory Weatherford, MD

Interview season at ORMC has started with a bang! Stacie Miller and Rich Brown are heading up the committee this year and have already done a great job. With a new pre-interview dining venue established, we are very excited to be hosting all of the applicants. We look forward to meeting all the new faces and getting to visit again with the students who rotated with us previously. We wish the best of luck to each student in this exciting time.

ACEP 2015 this year was a very exciting timew. All of the seniors were able to attend, as well as several attendings. Yes, we let the second year residents run the show, and they did great! The lectures were stimulating and covered such a wide breath of topics although, the nighttime parties may have been even better. Our alumni party was even back this year in full swing. It was such a treat to catch up with alumni from years past, but especially to see familiar faces who taught us so much as interns.

St. Lucie Medical Center
Rege Turner, DO, OMS-III

With the scientific assembly taking place in our backyard (two hours away in Orlando), the emergency medicine residents from St Lucie Medical Center certainly enjoyed the close proximity. Dr.'s Rick Carlson, Daniel Hohler, Kristen Hanrahan, and Thomas Caraballo placed first in the inaugural airway shootout. We also placed a close second in the annual residency jeopardy. We certainly enjoyed the excellent lecture line-up and the residency fair and look forward to this year's interview season and match. Until then, many residents will partake in a 4 mile "Run for the Pies" road race and will also attend our annual Christmas party at our ED directors home, Dr. Sasson.

As the calendar year comes to a close, here in Gainesville, we've started the interview cycle all over again. Just about every Friday for the next few months, eager 4th year medical students hoping to match in emergency medicine will be coming to learn more about our residency program. Residents and faculty get together to show the students the best that Gainesville and UFHealth have to offer. Keep an eye out in an upcoming EMPulse issue regarding the match results to learn a little more about the incoming class of 2019.

While many medical students are getting ready to graduate and figure out residency plans, in September, we had many current Florida emergency medicine residents present in Gainesville for a Life After Residency conference, where residents were able to meet with recruiters from large provider services to learn about job opportunities post-residency. Additionally, many practicing EM physicians gave lectures on how to balance work-life responsibilities, how to appropriately bill for a chart, and most importantly, how to best avoid the courtroom. Many thanks go out to the FCEP community and our very own, Dr. Falgiani, for putting together such an informative program for the residents.

University of Florida, Gainesville
Merisa Kaplan, MD, MPH

Finally, a BIG congratulations to Dr. Eike Flach and Dr. Christine Van Dillen on the birth of their beautiful daughter, Thea. Welcome to the Gator Nation!

University of Florida, Jacksonville
Nathan Bach, DO

Well its getting to that time of year where the rest of the U.S is building fires and strapping on their snow boots, while those of us here in Florida are forced to leave the beach early because the low 70's feels downright frigid. Since the last update so much has happened at UF Health Jacksonville. Our seniors attended ACEP 2015 in Boston. Several of our attendings have publications for which we wish to congratulate. Dr. Wears, a man who is always cool as a cucumber, published an article on "Human factors and ergonomics in the ED" in the Annals of EM. Dr. Sheikh's article on "Assessing patient activation and health literacy in the ED" has been accepted for publication in the American Journal of EM. Dr. Jacobson wrote an article entitled "Approach to the adult patient with acute dyspnea" which was recently accepted for publication in EM Clinics of North America. Dr. Sabato, our own master in case of disaster, was appointed to the National Disaster Life Support Board. The list of achievements and publications from our faculty goes on and on, so individual mention of everyone would nearly take this entire magazine. I guess you all need to stop being so darn productive. But, we are proud of you and appreciate your contributions to Emergency Medicine. On a final note, all of us here in the EM program in Jacksonville would like to congratulate our mentor, friend and program director Dr. Dave Caro and his lovely wife who just gave birth to a healthy baby boy. We welcome the newest member of the UF Health family and wish you all the best of luck!

University of South Florida
Taylor Matthews, MD

It has been an exciting few months at the University of South Florida. Our senior class just returned from ACEP Scientific Assembly in Boston. It was four jam-packed days of lectures, demonstrations, and networking. A hands-on musculoskeletal ultrasound course put on by our ultrasound team was well received. It was also a great opportunity to meet up with past residency graduates and old medical school friends. In addition, all three classes were able to attend the recent Life after Residency Workshop in Gainesville. Thoughtful, and sometimes humorous, tips to manage life and work were offered up by emergency physicians from a multitude of backgrounds. We are all grateful for these opportunities provided to us.

A giant congratulations goes out to our own Dr. Jason Wilson and his never tiring team, for their work on Praxbind (idarucizumab)! It was granted accelerated approval by the U.S. Food and Drug Administration for use in patients taking Pradaxa (dabigatran) where there is emergent need for reversal its blood-thinning effects. Stay tuned more announcements as our research program continues to grow.

Finally, we are deep into interview season, both medical students interviewing for residency and our third years interviewing for post-residency positions. Best of luck to everyone during this stressful and exciting time. Be sure to check out our newly minted Intagram profile (USFEMERGENCYMED) where we showcase our residents, faculty, and staff working hard and having fun!

Coding Tip

ICD-10 – External Causes
While using ICD-9, everyone knew that an E-code reported the external cause of an injury and, of course, it could never be reported as a primary diagnosis code.

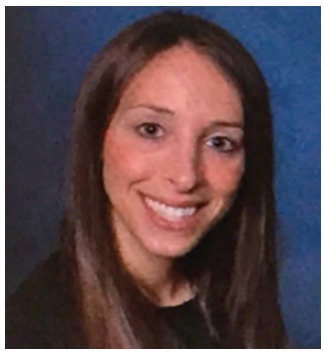
You know that the code options in ICD-10 have been greatly expanded. What we previously thought of as E-codes could now be a V-code, W-code, X-code or Y-code.

Please keep this in mind if you are making code choices in your EMR. Recently one of my providers chose W54.0XXA (Bitten by dog, initial encounter) which, if left alone, would be denied. It should be secondary to an open bite code, example, S61.451A (Open bite of right hand, initial encounter).

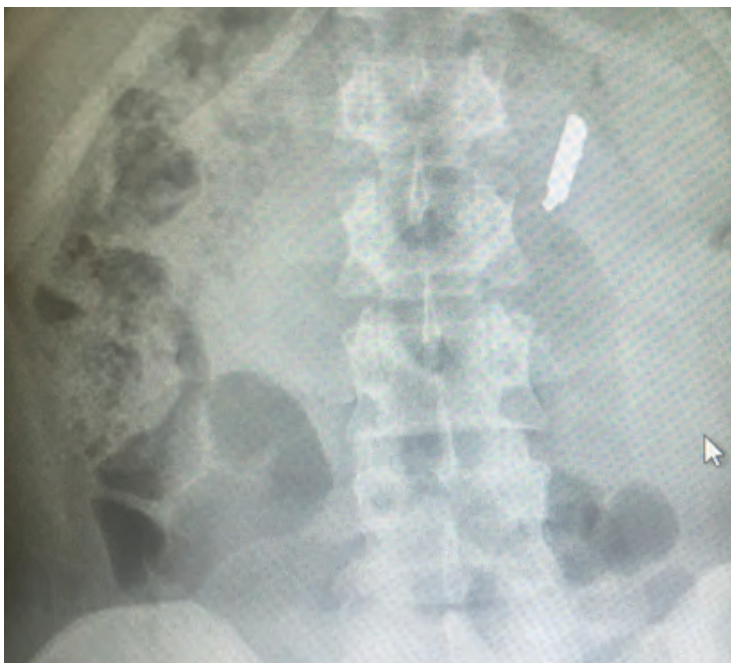
If your facility or EMR is requiring that you choose ICD-10 codes, you might want to stick with the S-codes for injuries and leave the External Causes to your coders. If you provide a thorough HPI, that will not be a problem.

Lynn Reedy, CPC, CEDC,
Director of Coding Services,
CIPROMS South Medical Billing,
Tampa Bay Emergency Physicians

Daunting Diagnosis



Karen Estrine, DO, FACEP, FAAEM
Editor-in-Chief



Question: A patient presents from prison and you receive this KUB? What is the diagnosis and how would you treat this?

Turn to page 25 for the answer!

Ashley Booth-Norse, MD, FACEP
FCEP Past President

Fair Payment for All: Balance Billing and its Impact

It is that time of year again! Legislative session. The 2016 Legislative session starts early this year and will run from January until March, unlike normal years in which is runs from March until May. If you read the EmPulse much, this article will seem very familiar to an article I wrote for the 2015 winter issue. The reason for this is during the 2015 legislative session, the FCEP and the emergency physicians throughout the state were able to defeat 2 bills that would have prohibited emergency physicians' ability to balance bill for emergency services and would have capped physician reimburse at a set amount. The fight is not over because the same legislation has already been re-filed for the 2016 legislative session and FCEP is already working on your behalf to defend FAIR PAYMENT for emergency services!

As the 2016 Legislative session gets heated up it has become evident that fair payment will be the top priority on our legislative agenda. Balance-billing is the practice of billing patients the difference in the cost of services rendered and the amount paid by the patient's insurance company. It typically occurs when specialists, including emergency medicine physicians, are non-par providers (out of the patient's insurance network).

You may be asking, "Why this is such a big issue"? Emergency physicians are under federal as well as Florida state law requiring them to provide emergency care regardless of the patient's ability to pay or insurance status. As such, forty to fifty percent of emergency care goes uncompensated according to the Centers for Medicare and Medicaid Services, and emergency physicians provide the most uncompensated care of all physicians. In addition, most health plans are not reimbursing adequately for emergency services, and there is a constant threat of significant decreases in reimbursement. According to a 2007 article in Annals of Emergency Medicine, payments for emergency visits have declined consistently since 1996. Decreasing reimbursement for emergency services and increasing amounts of uncompensated care have contributed to the closure of hundreds of emergency departments across the country. The lack of emergency resources threatens everyone's access to emergency care and the basic medical care safety net.

Federal law prohibits balance billing of Medicare and Medicaid patients. In January 2009, the California Supreme Court banned balance-billing entirely. However, physicians have won some battles. In 2010 the AMA and other organizations reached a $350-million settlement with United Health Group in a class action suit that was brought secondary to low out-of–network payments. Along similar lines a settlement was reached in a class action suit against Aetna which resulted in Aetna processing non-par claims at 239% of the Medicare level of reimbursement. The state of New York addressed balance billing in 2013 legislation and the state of Texas past legislation last year.

The prohibition of balance-billing would affect hospital based emergency medicine in additional ways. Insurance companies, knowing that emergency physicians are under federal and state mandates to provide care to their patients regardless of the rate of reimbursement, would have no incentive to enter into in-par network agreements with emergency physicians at fair reimbursement rates or even to contract at all. The only leverage EM physicians currently have is the ability to balance-bill patients the difference in what the insurer pays and the cost of services rendered. If EM physicians lose this ability, it will leave us with out any leverage to negotiate fair reimbursement rates. The only option would be to continue to bring long and costly class action suits against insurance companies in an effort to achieve fair and equitable payment.

The argument from the consumer's stand-point is that they get "stuck with large bills." The consumers are getting "stuck with large bills" because some insurance companies reimburse out of network physicians at such low rates and the consumer (our patients) are getting caught in the middle. As emergency physicians we have to ensure fair and equitable payment in emergent situations as the services being provided are at the request of the patient and the patient often has little or no time to determine if the emergency physician is an in-network provider due to the nature of the illness or injury. In addition, a ban on balance-billing in the state of Florida will inhibit emergency physicians' ability to obtain follow-up care for the patients they treat. If insurance companies have no incentive to negotiate fair reimbursement rate for specialist, secondary to a ban on balance-billing, there will be a further shortage of on-call specialist. This would be a real issue for specialist as well as patients. Without enough in network specialist, patients would have to go out of network or incur long waits for in network physicians; however, specialist would no longer be able to balance bill patients who choose to go out of network.

FCEP is working with all the parties involved in this legislation to come to a fair solution to the issue of balance billing and fair payment. FCEP has already participated in several legislative committee hearings as well as testified at a hearing before the office of insurance regulation and ACHA. This is our battle for this legislative session. If you normally attend EM Days I would ask that you PLEASE attend this year. This legislation, if past in its current language, could drastically change EM in the state of Florida. If you have never been to EM Days, I would urge you to consider participating this year. It is a great event and vital to the college and to our practice of Emergency Medicine.

Highlights from ACEP15 in Boston

By Jordan Celeste, MD
FCEP Board member

ACEP is celebrating another successful annual meeting. This year's event in Boston continued the trend towards being beyond merely informative, but towards being innovative and interactive as well. In addition to the extensive CME offerings, multiple events punctuated the learning and networking opportunities.

The week kicked off with the ACEP Council meeting, where members of ACEP chapters, sections, and associated organizations discussed and voted on resolutions pertinent to emergency care. Topics were once again broad, ranging from end-of-life care, to safe prescribing practices, and of course to the eternal favorite, medical marijuana. Not all resolutions were adopted, and some were referred to the ACEP Board of Directors for further action.

Elections were also held in conjunction with the council meeting. James Cusick, MD, FACEP from Colorado was unopposed as he transitioned from Vice Speaker of the Council to Speaker of the Council, with Col (ret.) John McManus, MD, MBA, MCR, FACEP from Georgia being elected as the new Vice Speaker. Incumbent candidates for the board of directors, William Jaquis, MD, FACEP from Maryland and our very own Vidor Friedman, MD, FACEP, were elected to a second term. Newly elected to the board were Christopher Kang, MD, FACEP, FAWM from Washington and Mark Rosenberg, DO, MBA, FACEP from New Jersey.

Dr. Friedman being honored for his year serving as Chair of EMF – incoming Chair Dr. Brooks Bock, left, ACEP staff and EMF Executive Director Bobby Heard, right.

In addition to discussing pressing issues and electing new candidates, the council meeting afforded the opportunity for ACEP leadership to speak to college priorities. Michael Gerardi, MD, FAAP, FACEP transitioned to the role of Immediate Past President, and provided a whirlwind year in review, with particular emphasis on fair payment. Jay Kaplan, MD, FACEP stepped into the role of ACEP President with impassioned speeches regarding the role of emergency medicine in the era of healthcare reform, and discussed payment and insurer issues as well. Rebecca Parker, MD, FACEP was chosen as President-Elect for the college, and had the chance to outline her vision of emergency medicine as the "nucleus of a new acute care continuum" – and also touched on reimbursement for emergency care. Needless to

(CONTINUED ON PAGE 20)

AMA President and emergency physician Steven Stack, MD, FACEP, addressing the ACEP Council

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ICD-10 Documentation Tip:

Key to Documenting Fractures

- **Laterality:** Left/ Right
- **Site of FX:** Proximal/ Shaft/ Distal
- **Displaced vs. Non-Displaced**
- **Mechanism of Injury:** How it happened
- **Etiology of fracture:** Traumatic/ Pathologic/ Osteoporosis/ Neoplastic Disease
- **Closed or Open**
- **Type:** Comminuted/ Greenstick/ Oblique/ Segmental/ Spiral/ Transverse/ Compression Burst/ Salter Harris

(Continued from page 18)
say, there was a consistent message about ACEP's active role in advocating for fair payment.

In addition to ACEP's efforts, though, the council was honored to hear the AMA President, Steven Stack, MD, FACEP speak on the issue as well. As a fellow emergency physician, we are fortunate to have Dr. Stack in such a prominent role, in which he is able to provide others with a clearer understanding of emergency care, and the vital role that emergency physicians play in the overall health care system.

Importantly, the ACEP Council awarded Andrew Bern, MD, FACEP with the Council Meritorious Service Award. Dr. Bern is one of South Florida's most dedicated emergency physicians – creating multiple ACEP Sections of membership, and serving as the Chair of the ACEP Board of Directors. Dr. Bern has given so much to ACEP over the years, so this award was well deserved. In addition, many other leadership awards were given during another wonderful President's Award Banquet on the final night of the meeting.

The Emergency Medicine Foundation managed to surpass its Council Challenge goal of raising more than $200,000 to fund emergency medicine research, while also hosting a lovely reception at the Isabella Stewart Gardner Museum – a unique venue for a very worth cause. NEMPAC also had a successful reception at the JFK Library, and also hosted additional fundraising events for emergency physicians running for Congress. Dr. Mark Plaster (MD, R) is seeking election to the House of Representative, while Dr. Raul Ruiz (CA, D) is looking to be elected to his second term. Dr. Joe Heck (NV, R) is running for an open Senate seat.

For the third year in a row, InnovatED brought the latest in technological advances and best practices to the exhibit floor, with over 55 companies showcasing their latest wares in a simulated ED environment. ACEP also continued enrollment in its Clinical Emergency Data Registry, or CEDR – a CMS-approved qualified clinical data registry that will allow users to collect and submit data for PQRS, MOC, as well as other professional and quality initiatives.

This brief summary barely scratches the surface of all of the offerings at this year's annual meeting. If you were unable to make the meeting – or just didn't make it to as many sessions as you would have liked – remember that you can access content online via VirtualACEP. And of course, you can start making your plans for ACEP16, which will be held in Las Vegas.


Dr. Jay Kaplan raising a glass to the 2015 ACEP Leadership award winners.


EMF Reception, awarding Blue Jay consuliting ED Director of the year award to Dr. Kathy Shaw of CHOP (and that's Dr. Friedman on the right)

Photo of the ACEP Council


Action shot of Dr. Kaplan

Rethinking the Emergency Physician's Approach to Pain

DID YOU KNOW?

- Pain is the chief complaint for 78% of ED visits.
- Over 100 million US adults experience chronic pain.
- Most patients are not addicts or drug seekers.
- If untreated or mismanaged acute pain may lead to chronic pain.
- Pain is often undertreated in the ED and EMS settings.
- Triage pain assessments are common; reassessments are not.

WHY SHOULD YOU CARE?

- HCAHPS satisfaction surveys include questions about patient pain experiences, which often begin in the ED and influence hospital ratings.
- Mismanaged or untreated pain often leads to ED and hospital readmissions resulting in financial penalties.
- The Joint Commission considers pain the 5th vital sign and has standards regarding pain management.

WHAT CAN PAMI DO FOR YOU?

- Offers online ED pain management, procedural sedation and patient safety resources (Ped and Adult).
- **Free** CME/CEU credits.
- **Free** tools such as dosing cards, non-pharmacologic management and patient education information.
- News briefs on patient safety and pain topics.
- Materials are multidisciplinary and can be used or adapted for hospitals, individuals, agencies, or training programs.

Submitted by Sophia Sheikh, MD, FACEP and Phyllis Hendry, MD, FACEP from University of Florida College of Medicine-Jacksonville, Department of Emergency Medicine. Drs. Sheikh and Hendry are investigators for the Pain Assessment and Management Project (PAMI) funded by the Florida Medical Malpractice Joint Underwriting Association.

America's Pain Epidemic

Patients may present to your ED with acute or chronic pain complaints and response to treatment is influenced by many factors such as genetics and past pain experiences. Pain relief is an integral component of quality care in the ED. Pain is often under recognized leading to inadequate treatment and numerous patient safety concerns. Education regarding the recognition and management of pain is lacking in all healthcare related professions, especially medical schools.

Emergency providers need an advanced skillset to safely and effectively address pain for a broad spectrum of patients with varied etiology, chronicity, and severity. This is coupled with the challenging issues of patient satisfaction, Joint Commission regulations, and opioid addiction.

Why PAMI? The Pain Assessment and Management Initiative (PAMI) is a free e-Learning and patient safety educational project that aims to improve pain recognition and management in the ED, EMS, and hospital settings.

The PAMI website, http://pami.emergency.med.jax.ufl.edu/, includes pain related resources, news updates and free CME/CEUs. PAMI learning modules and materials have been developed by a multidisciplinary panel of state and national experts, with content relevant for physicians, nurses, pharmacists, paramedics, and other providers. Project collaborators include the American Pain Society, Florida College of Emergency Physicians, Florida Hospital Association, Florida Society for Healthcare Risk Management & Patient Safety and other state organizations. PAMI is part of the Emergency Medicine Patient Safety Education Center (EMPSEC) http://patientsafety.emergency.med.jax.ufl.edu/.

For additional information and feedback on materials email emresearch@jax.ufl.edu or call 904-244-8617.

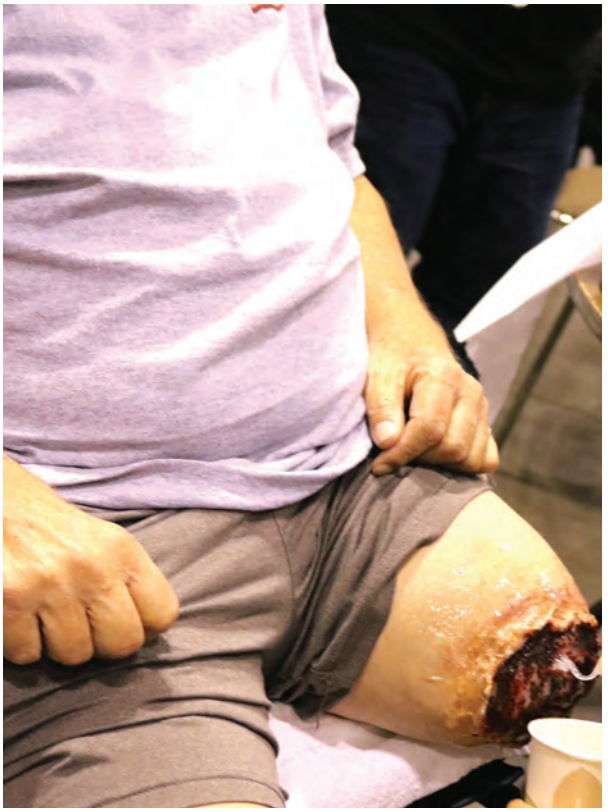
Like us on Facebook at UF Pain Assessment and Management Initiative – PAMI https://www.facebook.com/UF-Pain-Assessment-and-Management-Initiative-PAMI-852819621444015/timeline/.

PAMI ED
Pain Assessment and Management Initiative

EMERGENCY NURSES PARTICIPATE IN MCI DRILL

Terri Repasky
RN, CNS, MSN, CEN, EMTP

The Emergency Nurses Association (ENA) recently hosted its annual national symposium in Orlando. Over 3000 nurses attended with representatives from all 50 states and 21 countries. Over 190 educational programs were offered and included clinical, leadership, research and advance practice tracks. One of the most highly evaluated programs was a general session entitled "From Chaos To Culture: Are You Ready To Be Ready" featuring Mr. Daniel J. Nadworny, MSN, RN as the key speaker. Dan is a Clinical Director of ED and Urgent Care Operations in Massachusetts and has managed emergency response activities both nationally and internationally.

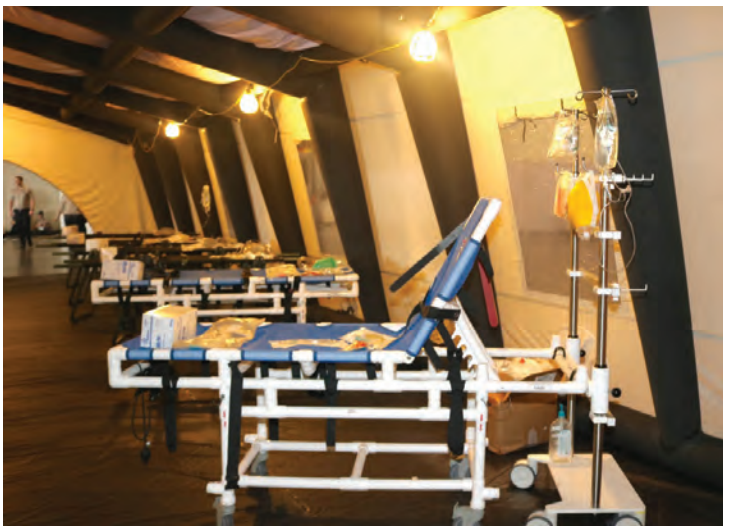


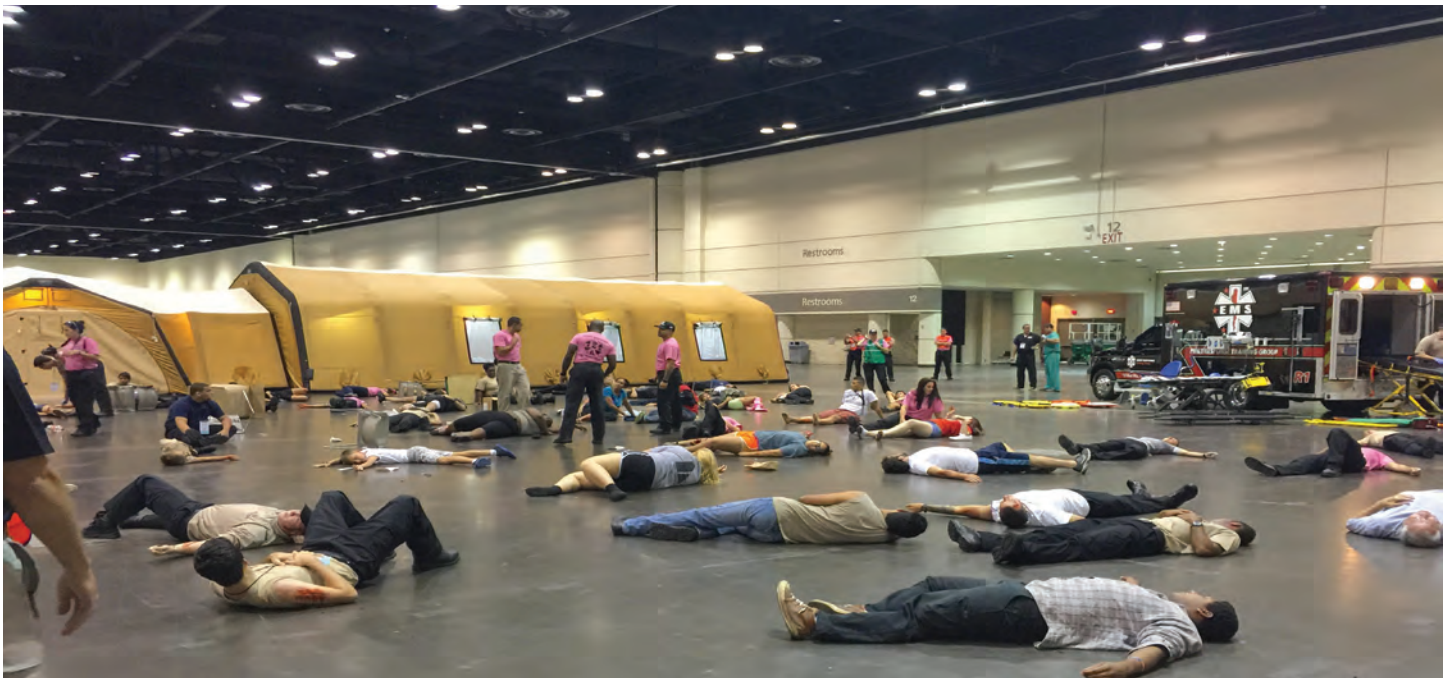
During this session a multiple casualty (MCI) drill was held. The scene was an active shooter at the ENA conference followed by an explosion when the shooter detonated an explosive device killing himself and injuring more victims. Eighty eight victims were moulaged, three alternative treatment site (ATS)/hospital tents set up, and 60 emergency nurse volunteers actively participated. Nurse volunteers were unaware of what they were volunteering for until the event happened. Nurses were gathered for what they thought was a lecture type presentation when suddenly gun shots were heard and "this is a drill" was announced; the situation of an active shooter was described. While their peers observed on a large screen in the general session area the volunteer nurses responded to the pre-staged area and were advised of the scenario. Safety was ensured and all were informed that the shooter was dead. The nurses were told to quickly triage the victims and remove them from the scene.

Sixty RNs, most of who had never worked together rapidly triaged the victims; classifying them as "green, yellow, red, or black" based on START criteria. The victims were then transported by the nurses to corresponding staging areas for re-triage or intervention. The "red" victims were taken inside one of the ATS where there were two Florida physicians in attendance. The nurse volunteers were not instructed as to whom would work where or given specific directions as to what to do. They quickly positioned and distributed themselves in the various staging areas, inside the ATS, and as transporters. The entire event was one hour and 15 minutes. Evaluators expressed how impressed they were with the nurses' response and ability to sort, care for, prioritize, and re-triage the victims.

The volunteer nurses who served as victims and responders as well as those who observed as audience members all provided positive feedback and said the event was an excellent learning experience. First Response Training Group, LLC of Orlando, Fl worked with ENA and coordinated the event. They hope to be able to do something similar at the next national ENA convention which will be held next fall in Los Angeles.


NURSE

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12
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Musings of a Recently Retired Emergency Physician

Wayne Barry, MD, FACEP

While perusing a popular physician blog known as SERMO, I read an entry by a comrade Emergency Physician known only as Robodoc911 to fellow bloggers which struck me right between the eyes (hopefully close to where my brain is housed). He posted that he recently survived a very busy shift in an 8 bedded ER at a small hospital. In the first 5 hours he saw 25 patients which included one STEMI patient (TNK and transferred), one hemodynamically unstable complete heart block patient (transferred), 3 surgical abdomen patients including ruptured diverticulitis, ischemic bowel, and appendicitis (2 pts admitted to surgery and one pt transferred), one DKA patient presenting in coma with initial pH of 6.61 (pt was intubated, resuscitated, and admitted to ICU), one patient with hip dislocation and another patient with a shoulder dislocation (procedural sedation, closed reduction and home for both patients), and finally a patient with ascending aortic dissection (central line, resuscitation, IV drips to control BP and patient was transferred)!

At midnight, the ED physician and a staff of 4 nurses were juggling the patients with aortic dissection, STEMI, DKA, hip dislocation and 2 of the patients with surgical abdomens all at the same time. All of the patients survived and were successfully managed during their ED stay and after they left the ED.

When Robodoc911's shift ended he thanked all of the nurses for their good work and silently patted himself on the back for a job well done.

On the next day, his ED Medical Director called to talk to him about the fact that the Hospital Administration was unhappy with him because 4 patients triage levels 4 & 5 left without being seen.

Have you ever felt the pain in your head and your gut like me and Robodoc911 after a similarly rough shift in the ED and getting judged with such a "metric" yardstick? This is what stress is all about. How do we reconcile the exhilaration of helping people, yes even saving lives beside talented dedicated team members, and then getting cut-down by the sword of clueless authority figures who just don't seem to "get it?"

I am not sure I have all of the answers to this complex question. One solution would be to do whatever it takes to attract your hospital administrators to make regular visits to the ER. Better yet manipulate them into spending most of a shift with you observing what you and your fellow team mates undergo during the course of your daily work. Some small number of enlightened administrators may already do this, but I bet these individuals few and far between. Most administrators along with some colleague doctors I know are scared to set foot in the ER, perhaps because they cannot deal with chaos and fast action upon which we ER workers thrive? Ask your elected officials to do the same visitation...on all levels of government, local, county, state, and even national. Some of them may be more used to chaos than hospital administrators!

I am not criticizing any of the customer service "hoops" we have learned to jump through because even though they may generate some extra stress at times, they are generally important for patient care. However, I do believe that the incredibly large "credibility gap" between what we ED workers actually do at work and what it is perceived by others that we do and how we do it is very stressful. This is because feedback to us is too often personally invalidating and devaluing to our extensive dedication and training. I challenge readers to share any strategies you may have to overcome this credibility gap in the perception of our collective performances so that we may enjoy a little more self-satisfaction for the jobs we do so that our patients may live and heal.

Daunting Diagnosis

Answer:
This patient presents from prison after swallowing the metal part of a ceiling sprinkler head. A KUB and CXR were ordered to see placement of the foreign body. According to the reading radiologist- the foreign body was read to be in duodenum.

Treatment for swallowed foreign bodies depends on characteristics of the foreign body:
-Blunt objects, if small enough may pass through the stool.

-Long objects (longer than 6-10 cm) and sharp objects are most serious. If too long or sharp, the foreign body may have difficulty passing the duodenal sweep.

-Batteries can cause liquefaction necrosis.

For these patients, Gastroenterology should be consulted for possible endoscopic retrieval. In the case if an obstruction or bowel perforation, General Surgery must be consulted. Conservative treatment is possible with some patients. Serial abdominal exams and observation of the patient maybe a good treatment choice if the object can easily pass through the GI tract.

(Question on page 15)

Resident Case Reports

Matthew Lowery, MD
LT, MC, USNR
Emergency Medicine, PGY-II
University of Florida COM – Jacksonville

Don't Skip Dialysis: A Case Report

A forty-seven year old white male presented via EMS for shortness of breath at 0700. He has a past medical history of ESRD, IDDM and HTN. At the scene, his oxygen saturation was 73% on room air. En route, EMS administered albuterol, ipratropium, and methylprednisolone. The patient failed the non re-breather mask and was placed on CPAP. The only recent history obtained from the patient was a missed dialysis session the day prior due to malaise and shortness of breath for two days. As this was the patient's first presentation to the University of Florida, prior records and history were unavailable.

Emergency Department Course:

Vitals at presentation were temperature 96.1 F, blood pressure 91/59, heart rate 78, respirations in the 40s, and 98% on non-rebreather. In the ED, the patient was immediately placed on BiPAP. Physical exam was notable for respiratory distress with accessory muscle use, audible rales, ketotic breath, and dry gangrene of left hand digits. Rapid sequence intubation ensued for failure on BiPAP. Initial ECG was a wide rhythm, which appeared to be atrial fibrillation with aberrancy. Repeat ECG yielded atrial fibrillation with a right bundle branch block. Calcium chloride and bicarb were ordered. Initial ABG <6.8/29/126 and POCT lactic acid 5.4. Other notable labs were Na+ 120, K+ 7.6, Cl- 71, bicarb 4, glucose 453, beta-hydroxybutyrate >45, POCT troponin I 0.12 and pro-NBP 40,842. Broad spectrum antibiotics were administered for possible lower lobe pneumonia on chest x-ray. MICU was consulted for admission and nephrology for emergent dialysis.

At 0851 the patient became asystolic and ACLS was initiated. Epinephrine, bicarb, and calcium were administered. The monitor then revealed wide complex tachycardia without a pulse. The patient was defibrillated and amiodarone was administered; ROSC was obtained.

At 0924, the patient was noted to have heart rate in 30s with a pulse. Given one round of epinephrine which increased the heart rate. Shortly after the patient found have a wide complex tachycardia with a pulse, cardioverted to narrow complex rhythm. A bicarb drip was ordered. An Uldall hemodialysis catheter was placed but the nephrology team deemed the patient too unstable for emergent dialysis (SBP had declined from low 100s to 80s-0s) and instead recommended continuous renal replacement therapy (CRRT).

At 1150 the ED nurse gave report to the MICU nurse. As transportation was prepared, the patient lost pulses at 1206. Following two rounds of CPR with calcium, bicarb and epi, ROSC was obtained. I escorted the patient immediately to the MICU.

Hospital Course:

During the first day in the MICU, the patient required Levophed, Vasopressin, epinephrine, Neo-Synephrine, amiodarone and insulin drips, in addition to CRRT. Overnight, the acidosis and electrolytes improved. The epinephrine and phenylephrine were discontinued while Levophed and Vasopressin were continuously weaned. On MICU day 2 the patient was following commands while intubated. Cefepime and Flagyl were continued for 7 days. On day 3 the insulin drip was discontinued. Day 4 the patient was extubated and vasopressors were discontinued. Day 5 the amiodarone drip was transitioned to oral and the patient transferred to internal medicine service. Hemodialysis resumed.

The MICU team consulted cardiology early in the admission. ECHO revealed diastolic dysfunction and large pericardial effusion. The patient was transferred to the cardiology service at day 9 for a left and right heart catheterization which revealed no coronary artery stenosis and pulmonary hypertension without a known cause. The pericardial effusion was deemed chronic and the patient was instructed to follow up as an outpatient. While on the cardiology service, documentation indicates the patient had a RBBB with aberrancy and this was believed to appear as a wide complex tachycardia, not ventricular tachycardia arrest. Atrial fibrillation resolved with correction of acidosis and electrolyte imbalance, and amiodarone was discontinued. However, telemetry showed the patient continued to have runs of wide complex tachycardia (ECG suggests atrial flutter vs atrial tachycardia). Electrophysiologists were consulted for evaluation of ablation of the arrhythmia which the patient refused. The patient was transferred back to the internal medicine. The pulmonary service was consulted for pulmonary hypertension, and after extensive work up (autoimmune labs and a V/Q scan) the cause was determined to be fluid overload. The IM team also consulted the orthopedic surgeons for the dry gangrene of the left digits, the patient declined amputation. At day 29, he was discharged to a nursing home facility.

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27th Annual EMERGENCY MEDICINE DAYS

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